

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0045187</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Farmington Country Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>701 South Main Street</u> <u>Farmington</u> <u>61531</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Fulton</u>		Officer or Administrator of Provider	(Signed) _____ (Date) _____																								
Telephone Number: <u>309-245-2407</u> Fax # <u>309-245-2420</u>			(Type or Print Name) <u>Stanley Stein</u>																								
IDPA ID Number: <u>23-2402757-002</u>		Paid Preparer	(Title) <u>President and CEO</u>																								
Date of Initial License for Current Owners: <u>12/1/95</u>			(Signed) _____ (Date) _____																								
Type of Ownership:		Paid Preparer	(Print Name and Title) _____																								
<table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>			<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		(Firm Name & Address) _____
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	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code _____			(Telephone) <u>()</u> Fax # ()																								
In the event there are further questions about this report, please contact: Name: <u>Karl Baker, BKD, LLP.</u> Telephone Number: <u>314-231-5544</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									

STATE OF ILLINOIS

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Facility Name & ID Number Farmington Country Manor# 0045187 Report Period Beginning: 1/1/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>92</u>	Skilled (SNF)	<u>92</u>	<u>33,580</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>		3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>92</u>	TOTALS	<u>92</u>	<u>33,580</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,990</u>	<u>10,879</u>	<u>2,511</u>	<u>30,380</u>	8
9	SNF/PED					9
10	ICF	<u>0</u>	<u>0</u>	<u>0</u>		10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,990</u>	<u>10,879</u>	<u>2,511</u>	<u>30,380</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.47%

D. How many bed-hold days during this year were paid by Public Aid?

18 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/1/95

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/1/95 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 92 and days of care provided 2,494Medicare Intermediary Riverbend Government Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

Farmington Country Manor

0045187

Report Period Beginning:

1/1/02

Ending:

12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	151,020	10,236	16,280	177,536		177,536	(9,165)	168,371			1
2	Food Purchase		132,545		132,545		132,545		132,545			2
3	Housekeeping	90,243	10,313		100,556		100,556		100,556			3
4	Laundry	48,903	12,090		60,993		60,993		60,993			4
5	Heat and Other Utilities			101,046	101,046		101,046		101,046			5
6	Maintenance	35,055	11,185	25,010	71,250		71,250		71,250			6
7	Other (specify):*											7
8	TOTAL General Services	325,221	176,369	142,336	643,926		643,926	(9,165)	634,761			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,079,235	26,869	36,683	1,142,787		1,142,787		1,142,787			10
10a	Therapy	98,528	5,294		103,822		103,822		103,822			10a
11	Activities	44,242	3,132	8,891	56,265	(7,866)	48,399		48,399			11
12	Social Services	33,874			33,874		33,874		33,874			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,255,879	35,295	45,574	1,336,748	(7,866)	1,328,882		1,328,882			16
	C. General Administration											
17	Administrative	53,430		197,202	250,632		250,632	(194,414)	56,218			17
18	Directors Fees											18
19	Professional Services			10,884	10,884		10,884	25,183	36,067			19
20	Dues, Fees, Subscriptions & Promotions			14,758	14,758		14,758	(9,116)	5,642			20
21	Clerical & General Office Expenses	106,180	8,184	100,465	214,829		214,829	(44,516)	170,313			21
22	Employee Benefits & Payroll Taxes			338,898	338,898	(1,875)	337,023	154,862	491,885			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,019	3,019	1,875	4,894	4,683	9,577			24
25	Other Admin. Staff Transportation			3,582	3,582		3,582		3,582			25
26	Insurance-Prop.Liab.Malpractice			97,422	97,422		97,422		97,422			26
27	Other (specify):*											27
28	TOTAL General Administration	159,610	8,184	766,230	934,024		934,024	(63,318)	870,706			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,740,710	219,848	954,140	2,914,698	(7,866)	2,906,832	(72,483)	2,834,349			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number

Farmington Country Manor

#0045187

Report Period Beginning:

1/1/02

Ending:

12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			92,607	92,607		92,607	(3,517)	89,090			30
31	Amortization of Pre-Op. & Org.			14,792	14,792		14,792		14,792			31
32	Interest			241,838	241,838		241,838	(636)	241,202			32
33	Real Estate Taxes			42,000	42,000		42,000		42,000			33
34	Rent-Facility & Grounds							6,514	6,514			34
35	Rent-Equipment & Vehicles					7,866	7,866	4,366	12,232			35
36	Other (specify):*											36
37	TOTAL Ownership			391,237	391,237	7,866	399,103	6,727	405,830			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,932	64,094	68,026		68,026		68,026			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,274	50,274		50,274		50,274			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		3,932	114,368	118,300		118,300		118,300			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,740,710	223,780	1,459,745	3,424,235		3,424,235	(65,756)	3,358,479			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/02

Ending:

12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,517)	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(635)	32		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(51,934)	21		24
25	Fund Raising, Advertising and Promotional	(9,116)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (65,203)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(553)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (553)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (65,756)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Farmington Country ManorID# 0045187Report Period Beginning: 1/1/02Ending: 12/31/02

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/02

12/31/02

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(3,517)	0	0	0	0	0	0	0	0	0	0	(3,517)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(636)	0	0	0	0	0	0	0	0	0	0	(636)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	6,514	0	0	0	0	0	0	0	0	0	6,514	34
35	Rent-Equipment & Vehicles	0	4,366	0	0	0	0	0	0	0	0	0	4,366	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,153)	10,880	0	0	0	0	0	0	0	0	0	6,727	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(65,203)	(553)	0	0	0	0	0	0	0	0	0	(65,756)	45

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/02

Ending:

12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
American Health Corporation	100	Oak Trace				
American Health Corporation	100	Terace Oaks				
American Health Corporation	100	Colonial Haven				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.



YES



NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	1 Dietary	\$ 9,165	American Health Corporation	100.00%	\$	\$ (9,165)
2	V	17 Administrative	197,202	American Health Corporation	100.00%	2,788	(194,414)
3	V	19 Professional Services		American Health Corporation	100.00%	25,183	25,183
4	V	21 Clerical & Gen. Office Exp.		American Health Corporation	100.00%	7,418	7,418
5	V	22 Emp. Benefits & Payroll Taxes		American Health Corporation	100.00%	154,862	154,862
6	V	24 Travel & Seminar		American Health Corporation	100.00%	4,683	4,683
7	V	34 Rent-Facility & Grounds		American Health Corporation	100.00%	6,514	6,514
8	V	35 Rent-Equipment & Vehicles		American Health Corporation	100.00%	4,366	4,366
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 206,367			\$ 205,814	\$ * (553)

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Farmington Country Manor # 0045187 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **Farmington Country Manor**# **0045187**

Report Period Beginning:

1/1/02

Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization American Health CorporationStreet Address 525 Plymouth Road, Suite 310City / State / Zip Code Plymouth Meeting, Pennsylvania 19462Phone Number (610) 832-2059Fax Number (610) 834-2937

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Patient Days	108,053	4	\$ 72,274	\$ 30,380	\$ 20,320	1
2	19	Professional Services	Patient Days	108,053	4	89,569	30,380	25,183	2
3	21	Clerical & Gen. Office Exp.	Patient Days	108,053	4	20,630	30,380	5,800	3
4	22	Emp. Benefits & Payroll Taxes	Patient Days	108,053	4	478,815	30,380	134,623	4
5	24	Travel & Seminar	Patient Days	108,053	4	0	30,380	0	5
6	34	Rent-Facility & Grounds	Patient Days	108,053	4	23,168	30,380	6,514	6
7	35	Rent-Equipment & Vehicles	Patient Days	108,053	4	15,530	30,380	4,366	7
8	17	Administrative	Hours	2,080	4	(127,950)	285	(17,532)	8
9	19	Professional Services	Hours	2,080	4	0	285	0	9
10	21	Clerical & Gen. Office Exp.	Hours	2,080	4	11,804	285	1,617	10
11	22	Emp. Benefits & Payroll Taxes	Hours	2,080	4	147,713	285	20,240	11
12	24	Travel & Seminar	Hours	2,080	4	34,181	285	4,683	12
13	34	Rent-Facility & Grounds	Hours	2,080	4	0	285	0	13
14	35	Rent-Equipment & Vehicles	Hours	2,080	4	0	285	0	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 765,734	\$	\$ 205,814	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Health Care Cap. Finance		X	mortgage			\$ 2,200,000	\$ 2,026,441	6/1/04	11.3300	\$ 234,690	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Other interest										7,148	6
7												7
8												8
9	TOTAL Facility Related						\$ 2,200,000	\$ 2,026,441			\$ 241,838	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,200,000	\$ 2,026,441			\$ 241,838	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$

Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Farmington Country Manor**# **0045187**

Report Period Beginning:

1/1/02

Ending:

12/31/02**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$ 42,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 42,284	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 284	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 41,716	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 42,000	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997 47,364	8	
	1998 48,457	9	
	1999 40,524	10	
	2000 49,241	11	
	2001 42,284	12	
		FOR OHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2001 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Farmington Country Manor COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0045187

CONTACT PERSON REGARDING THIS REPORT Bob Conner

TELEPHONE 610-832-2059 FAX #: 610-834-2937

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u> </u>	<u>Building</u>	\$ <u>42,284.00</u>	\$ <u>42,284.00</u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u>42,284.00</u>	\$ <u>42,284.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:

31,130

B. General Construction Type:

Exterior Brick

Frame Block

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home			\$ 34,115	1
2					2
3	TOTALS			\$ 34,115	3

Facility Name & ID Number Farmington Country Manor

0045187

Report Period Beginning:

1/1/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	92		1986		\$ 2,264,583	\$ 83,777	30	\$ 75,486	\$ (8,291)	\$ 1,246,609	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1987 Additions		1987		2,769	110	25	110		1,728	9
10	1988 Additions		1988		51,628	1,674	25	1,674		26,180	10
11	1989 Additions		1989		36,365	1,436	20	1,436		24,800	11
12	1990 Additions		1990		11,397	557	15	557		10,009	12
13	1991 Additions		1991		41,089	2,740	15	2,740		34,244	13
14	1992 Additions		1992		4,778	318	15	318		3,343	14
15	1993 Additions		1993		4,673	191	15	191		3,621	15
16	1994 Additions		1994		16,921	1,129	15	1,129		9,594	16
17	1995 Additions		1995		1,742	116	15	116		871	17
18	Carpet		2001		300	44	3	100	(56)	144	18
19										411	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$ 2,436,245	\$ 92,092		\$ 83,857	\$ (8,347)	\$ 1,361,554		70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 29,212	\$ 515	\$ 4,173	\$ 3,658	7	\$ 11,794	71
72	Current Year Purchases	7,422		1,060	1,060	7	1,060	72
73	Fully Depreciated Assets	262,411					262,411	73
74								74
75	TOTALS	\$ 299,045	\$ 515	\$ 5,233	\$ 4,718		\$ 275,265	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,769,405	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 92,607	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 89,090	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,517)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,636,819	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Use	2001 Ford Van	\$ 655.48	\$ 7,866	17
18					18
19					19
20					20
21	TOTAL		\$ 655.48	\$ 7,866	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2003 \$ _____

13. _____/2004 \$ _____

14. _____/2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
							1	Licensed Occupational Therapist		190 hrs	\$ 4,750
2	Licensed Speech and Language Development Therapist		533 hrs	18,666					533	18,666	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		196 hrs	3,802			4,212	196	8,014		4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10	Academic Education		hrs								10
11	Exceptional Care Program										11
12											12
13	Other (specify):										13
14	TOTAL			\$ 27,218		\$	\$ 4,435	919	\$ 31,653		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 136,913	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 9,234)	433,998		3
4	Supply Inventory (priced at)	3,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,712		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	720,073		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,297,696	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	34,115		13
14	Buildings, at Historical Cost	2,264,583		14
15	Leasehold Improvements, at Historical Cost	171,662		15
16	Equipment, at Historical Cost	299,045		16
17	Accumulated Depreciation (book methods)	(1,636,819)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	20,955		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): mort., tax, capital reserve	204,158		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,357,699	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,655,395	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 48,073	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	34,352		29
30	Accrued Salaries Payable	138,559		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,865		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Current Liabilities	500,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 723,849	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,992,089		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,992,089	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,715,938	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (60,543)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,655,395	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (57,215)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (57,215)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,392	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) MISC.	(5,720)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (3,328)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (60,543)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,708,568	1
2	Discounts and Allowances for all Levels	(588,051)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,120,517	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	207,195	6
7	Oxygen	22,130	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 229,325	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	45,086	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	31,632	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 76,718	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	67	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 67	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,426,627	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	643,926	31
32	Health Care	1,336,748	32
33	General Administration	934,024	33
	B. Capital Expense		
34	Ownership	391,237	34
	C. Ancillary Expense		
35	Special Cost Centers	68,026	35
36	Provider Participation Fee	50,274	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,424,235	40
41	Income before Income Taxes (line 30 minus line 40)**	2,392	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,392	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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Facility Name & ID Number Farmington Country Manor# 0045187Report Period Beginning: 1/1/02Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		2,080	\$ 52,821	\$ 25.39	1
2	Assistant Director of Nursing		735	16,166	21.99	2
3	Registered Nurses		3,683	86,547	23.50	3
4	Licensed Practical Nurses		18,124	299,044	16.50	4
5	Nurse Aides & Orderlies		54,513	554,555	10.17	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides		5,799	115,400	19.90	8
9	Activity Director		2,080	25,146	12.09	9
10	Activity Assistants		2,265	19,096	8.43	10
11	Social Service Workers		2,080	33,874	16.29	11
12	Dietician					12
13	Food Service Supervisor		2,080	21,557	10.36	13
14	Head Cook		5,706	46,506	8.15	14
15	Cook Helpers/Assistants		11,651	82,958	7.12	15
16	Dishwashers					16
17	Maintenance Workers		2,930	35,055	11.96	17
18	Housekeepers		11,580	90,243	7.79	18
19	Laundry		5,334	48,903	9.17	19
20	Administrator		2,080	53,430	25.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager		8,034	106,180	13.22	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator		2,080	42,078	20.23	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)		142,834	\$ 1,729,559 *	\$ 12.11	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	140	\$ 4,984		35
36	Medical Director	36	12,000		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	1,000		44
45	Social Service Consultant				45
46	Other(specify) <u>Dentist</u>	24	1,897		46
47					47
48					48
49	TOTAL (lines 35 - 48)	306	\$ 21,681		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Ending: 12/31/02

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number Farmington Country Manor

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? N/A
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,909 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Genesis Health Ventures operated facility until 10/31/00
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 50,370
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 377
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? See Attached
Attach invoices and a summary of services for all architect and appraisal fees.